GENERAL MEDICINE

Elective Report- Hospital Umum Sarawak, Borneo – April/May 2012

I undertook my elective in the Malaysian state of Sarawak. Borneo is a large island off the coast of mainland Malaysia. It is divided into a Malaysian ruled area and an Indonesian ruled area as well as the state of Brunei. The Malaysian part is split into two states, Sabah and Sarawak. The hospital I was attached to is located in the capital of Sarawak which is Kuching. As the biggest hospital in the state of Sarawak people would attend from far and wide.
I spent the placement shadowing the general medical team.

Sarawak has a population of 2.4million people. It differs from mainland Malaysia in the presence of the indigenous tribes of Borneo which make up a large population. There are 40 ethnic sub groups each with its own lifestyle, language and culture. The state also contains vast expanses if rainforest.

Objectives

"1. Describe the pattern of disease/illness of interest in the population with which You have worked and discuss this in the context of global health."
What are the most prevalent conditions in Sarawak, Malaysia? How do they differ from the UK?

In the context of global health, infectious disease is the more prevalent entity in Sarawak, Malaysia. This is evidenced by a recent outbreak of Hand, foot and mouth disease. Dengue and Meliodosis are also common. The UK has an incidence of 36 deaths in a 100,000 people compared to 762 deaths per 100,000 people in Malaysia. Other commoner conditions in addition to those mentioned earlier are HIV/AIDS, Leptosporosis and TB.
The city of Kuching however which the hospital services is well developed and chronic disease is more prevalent. As well as a genetic predisposition in south east Asians, Experiencing the diet, I found it contains a lot of salt and sugar in the dishes, therefore it is unsurprising diseases like hypertension and diabetes are more common. There also seemed to be a high number of individuals who smoked and we were told COPD is becoming more and more prevalent.
There was also an opportunity to go to a rural clinic with doctor's form the hospital; it was interesting to note the stark differences within one state and the effect of clean water, sanitation and economic development.
Patient education and social status is also different from the UK which I felt had an impact on the pattern of disease. Patient's health behaviours and attitudes towards their health and doctor differed markedly from the UK. This may have influenced the pattern of disease, for example cultural beliefs in alternative medicines affect what could be simple conditions to deal with as patients present later than they would have in the UK. Many villages contain shayman.

"2. Describe the pattern of health provision in relation to the country in which you Have worked and contrast this with other countries, or with the UK."

How is the health service delivered in Sarawak, Malaysia? How does it differ from the UK?

In the cities the pattern of health provision is very similar to the UK. The set consists of primary healthcare with family medicine doctors, secondary and tertiary services in hospitals. However patients can have access to a consultant physician straight away by booking an appointment which differs from the UK system of referral via your GP as the sole form of access to a consultant. In Malaysia the post of medical care practitioners also exist who are half way between doctors and nurses. The are allowed to perform minor procedures and certain cases are allocated to them to lighten the doctors load.

To reach the rural folk, doctors from the hospital conduct weekly rural health clinics. This is for those who do not have access to mainstream services. For the most part in the UK people have close access to a doctor. In rural areas, lack of money and transport mean some do not have access to services. There are also around 187 static health clinics that allow provision of healthcare to just over 2/3 of Sarawak's population.

A helicopter service called the flying doctors also exists. This allows delivery of healthcare to the more hard to reach folk. Clinics by doctors from the cities are also run. These health provisions allow approximately 90% of Sarawakians to have access to healthcare.

3. Health Related Objective
Learn about the management of a common condition in Sarawak, Malaysia. Describe its investigation and management.

The disease I saw being managed most frequently was diabetes. I shadowed a few diabetic clinics and gained insight into how this chronic, worldwide disease affected and was managed in a unfamiliar environment. I felt I was back in my OSCE's as I observed the doctors explaining the management of Diabetes to their patients. The doctors had a patient centred approach, coming up with plans in conjunction with patient with regard to their management. The management does not differ from the U.K. The first stage of treatment involves lifestyle management, encouraging changes in diet and promoting exercise. Failure of this meant patients were then started on medication. There is no similar body to NICE and drugs are often chosen at the discretion of the doctors. Patients who still had poor control were then started on insulin.

The similarity extends to the MDT management of diabetic patients with input from the diabetic nurse. Patients are encouraged to keep a record of their blood sugars at home using home monitoring equipment. However patients are not subject to compulsory annual foot and eye checks for complications.

One issue I found with the management is that there was sometimes a language barrier. Doctors from the mainland spoke a different dialect of Malay. There were no formal interpreters and the nurses had to translate when possible.

Another thing I observed was the involvement of families in the patients care. Many elderly

patients were accompanied by members of their family who took active decisions in the patients care. The lack of autonomy of the patient meant that sometimes adherence was difficult when this support network was not present.

4. Learn about being part of the MDT in an unfamiliar environment and reflect on a specific experience.

Despite being thousands of miles from the UK, the importance of the MDT was highlighted on many occasions. An experience that stands out was a visit to the geriatric ward in the hospital. There were many patients with differing pathologies. A patient that stood out was a lady who had a stroke leaving her with a right sided hemiplegia. I was intrigued to observe if the multi-disciplinary care was given on a par with the UK.

The first thing I noticed is that the patient was on a general geriatric ward with other elderly patients and not on a specialist stroke ward. This would have negatively affected the amount of care that is able to be given. The nurses on the ward were an active part of the patients care and liaised with the doctors. The patient's granddaughter however was also present and was taking care of a lot of the patient's needs. The patient was assessed by occupational therapy and was also due for physiotherapy assessment. There appeared to be less interaction between these professionals than in the UK.

With a condition like stroke that has many facets to its care I observed the importance of the MDT in the care of the stroke patient. The patient did not receive the level of specialist care that you would expect in the UK with its specialist stroke wards. I was unable to observe an emergency suspected stroke which would have been interesting to note the protocol for care.

In the UK patients are assessed for suitably for thrombolysis within 4.5 hours and there is a big public campaign for awareness of recognition of stroke with the FAST campaign. However public health campaigns in countries like Malaysia seem to be aimed more at tropical disease prevention. This maybe because it affects younger patients and therefore more emphasis is placed on it.